WASHINGTON STATE DEPARTMENT OF LICENSING

Positive/Refused Drug/Alcohol Test Report

Driver's name *(Last, First, Middle Initial)*		Date of birth *(If available)*
Driver license number *(If available)*	Social Security number	
Employer/Motor carrier name		
Employer/Motor carrier mailing address		
City	State	ZIP code
Consortium/Contractor name		
Consortium/Contractor mailing address		
City	State	ZIP code
Reason for test ☐ Pre-employment ☐ Random ☐ Reasonable suspicion ☐ Post accident ☐ Return to duty ☐ Follow-up		

Medical Review Officer

Specimen ID number		Date of test
Laboratory name		
Drug(s) found	Adulterant(s) found	Split sample tested? ☐ Yes ☐ No

Breath Alcohol Technician

Test number	Date of test	Time of test
Instrument name	Instrument serial number	

Attestation

I the Medical Review Officer/ Breath Alcohol Technician declare by signing below that:

The driver above has:

☐ tested positive for: ☐ drug(s) ☐ alcohol (0.04 or above)

☐ refused test by: ☐ adulteration ☐ substitution of a sample
☐ other _____

The motor carrier, employer, or consortium above has a program subject to the federal requirements under 49 CFR 40.

I am properly trained and certified as of the date of this test to administer the alcohol or review the drug test(s) cited above and have accurately followed the protocols for testing in accordance with 49 CFR Part 40 in verifying or confirming the results.

I further declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

_____
PRINT OR TYPE name of medical review officer/ breath alcohol technician — Title

_____
Address — (Area code) Telephone number

_____
Date and place

X _____
Signature

When completed, mail to: **Suspensions, Department of Licensing, PO Box 9030, Olympia, WA 98507-9030** or fax to **(360) 570-7826**.

The Department of Licensing has a policy of providing equal access to its services. If you need special accommodation, please call (360) 902-3900 or TTY (360) 664-0116.